LARGE JAIL NETWORK

BULLETIN

Summer 1993

Contents

The ***Large Jail Network Bulletin*** is prepared by staff of LIS, Inc., for the U.S. Department of Justice, National Institute of Corrections. The contents of this document do not necessarily reflect the official views or policies of the ***National*** Institute of Corrections. To submit questions, comments, or materials, please write to the NIC Information Center, 1860 Industrial Circle, Suite A, Longmont, Colorado, 80501, or call (303) 682-0213.

Introduction

This issue of the ***Large Jail Network Bulletin*** presents several articles that I think readers will find interesting. From California's Contra Costa and Orange Counties, respectively, we have discussions of health care screening and privatization of jail health services. Perspectives on easing the transition to direct supervision are provided by a University of South Florida contributor. A Fairfax County, Virginia writer outlines that area's recent multi-agency effort to improve minorities' perceptions of the criminal justice system.

A summary of the complex PONI process is provided in an article from Duval County, Florida, and writers from Allegheny County, Pennsylvania describe their mental health services, which emphasize a continuum of care after discharge.

I look forward to meeting with you at the upcoming Large Jail Network meeting in Denver, where we will be discussing issues in privatization, contracting for bedspace, and women offenders' medical and programming needs. Thank you for helping to make the Network an effective information exchange.

Mike O'Toole
Chief, NIC Jails Division
Longmont, Colorado

Neutralizing the Negative Impact of Organizational Change During the Transition Process

by Linda G. Smith, Ph.D., University of South Florida, Tampa, Florida

Nothing is permanent, except change. - Heraclitus, 500 B. C.

Although large jails represent a considerable portion of budgets allocated at the local level, researchers from the fields of business, psychology, sociology, and criminology have conducted few studies of organizational work issues in correctional settings. Issues such as job stress, anxiety, and job satisfaction have been studied primarily in the private sector, although jails encounter many of these same problems in their organizations. And, like their counterparts in business, jail administrators can benefit from meaningful research that can help improve management practices.

Change creates stress in employees even when the change itself is beneficial.

One area of management research that could be useful to administrators of large jails is the study of change in organizations and the stress, anxiety, job satisfaction, absenteeism, job performance, and job turnover experienced as a result of change by those who work in these facilities. The dynamics associated with change can be assessed by surveying both the organizational climate and the attitudes of staff. There has been a rapid growth in research addressing change and organizational climate. Again, much of this has occurred in the private sector because of growing businesses and executives' subsequent interest in workers well-being (Sauter, Hurrell, and Cooper, 1989). Previous research has indicated, however, that those who work in human service organizations, especially correctional organizations, are particularly vulnerable to the debilitating effects of stress and other work-related issues (Cheek and Miller, 1983; Brown, 1987). Because most jails are also experiencing unprecedented growth and change, additional studies are needed to improve the quality of life for those who work in these settings.

The impact of change on organizational work issues in jails is especially important in the context of the transition process as jails continue to make the major move in correctional management style from linear intermittent surveillance (LIS) to podular direct supervision (PDS). As a transition signifies change, and change affects employees and their quality of life, the ways administrators and supervisors handle that change can make a considerable difference in how their employees will react to it, and in the subsequent impact the change will have on work-related issues.

PDS has been an accepted method of facility operation for over a decade. However, many organizations attempting to make the transition from an LIS- to a PDS-operated facility often meet with strong resistance. Although a change in correctional management style inevitably creates an atmosphere that is both dynamic and uncertain, this change can be presented and perceived as a positive experience. It has been argued that if an organization". . . is not growing, not changing, not meeting the current needs of society, and preparing to meet its future needs, it is declining*' (Higgins and Vincze, 1986, p. 29).

Change is a predominant factor in the management of organizations today (Hodgetts and Kuratko, 1988, p. 65). Correctional organizations, particularly large jails, must constantly change to keep pace with the many demands placed upon them. Understanding change and developing strategies to implement it successfully have become major challenges for jail administrators. In addressing that challenge, administra-

tors and supervisors must remember that change creates stress in employees even when the change itself is beneficial.

Stressors Related to Organizational Change

Many stressors can develop as a result of organizational change. According to Duffee (1986) and Williamson (1990). change may create:

- new role demands (underload or overload);
- role ambiguity (lack of leadership, goals, and well-defined job descriptions); or
- role conflict.

As part of the transition, new policies and procedures are likely to be implemented. The new work environment may be different from the old one; supervisors may have different expectations for workers' performance. Staff may not be adequately prepared for change because they have not been given sufficient training. Supervisors may fail to provide staff with needed support prior to, during, and after the transition. Conflicts with supervisors, co-workers, and/or inmates may occur. In general, the overall organizational climate may not be conducive to change, which may create resistance. This, in turn, makes it likely that the implementation of new management practices will be difficult or may fail.

Changing from a facility using intermittent supervision to one using direct supervision puts special stresses on staff. For example, in facilities using direct supervision, line staff ate expected to assume the role of managers, whereas they had few decision-making powers in the LIS facility. Their new role may initially be **uncomfortable for the staff in other ways. Line staff in PDS facilities are required to communicate** with inmates; in LIS facilities, communication was generally prohibited.

Changing from a facility using intermittent supervision to one using direct supervision puts special stresses on staff.

New policies and procedures that reflect a proactive rather than a reactive management style generally accompany the change in management philosophy, and employees need time to become familiar with these new practices. The work environment is likely to include sophisticated technological equip ment utilizing computers for control and communication, which may be unfamiliar to the staff. Line staff will be expected to use good management practices to accomplish tasks, yet they may never have been provided with management training. Any one or a combination of such changes can negatively affect the transition process and create stress/ distress in staff.

Stress can be good in some instances and debilitating (distress) in others (Cournoyer, 1988). Although good stress can improve performance, distress can affect workers' well-being and their quality of life. Notably, stress that is debilitating can increase employees* health problems, cause declines in work performance, lower job satisfaction, increase anxiety, and cause burn-out, absenteeism, and job turnover-all of which negatively affect the organization It is possible, however, by using good management practices, for administrators and supervisors to eliminate, or at least limit, the debilitating effects of stress that can result from the transition process.

Implementing a Successful Change Process

How does a correctional organization implement an effective and efficient transition in its management practices, especially if employees are resisting the change? Three basic phases of a planned-change effort can be identified, borrowing from Kurt Lewin's (1958) definition of the change process:

- unfreezing;
- changing; and
- refreezing.

In the first phase, **unfreezing,** those responsible for facilitating change

must create a consciousness of the need for a shift in the organization's focus. This can be accomplished by pointing to areas of dissatisfaction with current practices. Although in some instances this may involve conflict, the conflict can be a positive force in the unfreezing phase since it helps individuals break old habits and consider alternative ways of doing things (Hodgetts and Kuratko, 1986, p. 65). However, employees may resist management's efforts to encourage change if the attempts involve the following kinds of failures:

- failure to be specific about the change;
- failure to show why the change is necessary;
- failure to allow people affected by the change to have a say in planning it;
- failure to consider the work group's habit patterns;
- failure to keep employees informed about the change;
- failure to prevent the creation of excessive work pressure during the change; and
- failure to deal with employee anxiety regarding job security (Wismer, 1979, p. 31).

Wismer (1979, p. 31) identifies several ways that management can reduce resistance to change:

- involving the employees in planning the change;
- providing accurate and complete information regarding change;
- giving employees a chance to air their objections;
- taking group norms and habits into account;
- making only essential changes; and
- learning to use proper problem-solving techniques.

In the second phase, changing, management implements the new practices. Strategies, people, tasks, and technology may require modification (Hodgetts and Kuratko, 1986, p. 66). For PDS, this phase may mean constructing a new facility, although some administrators implement direct supervision without redesigning the facility. This phase may take much longer than originally planned if part of the change process involves new construction. Time constraints can create a great deal of stress and anxiety among line staff and management. All of the stress and anxiety may start to affect employees' sense of well-being as well as to create resistance to the change.

The third and final phase in the change process is the refreezing phase, which is designed to sustain the momentum of the change. During this phase, management is expected to provide emotional and resource support, particularly when difficulties are encountered. One important aspect of this support is to give employees positive reinforcement when they achieve the desired outcomes of the organizational change.

In making the transition from indirect surveillance to direct supervision. most administrators have been able to carry out the first two phases successfully. That is, they have created a sense of the need for change by introducing the benefits of a PDS-operated facility and pointing to areas of dissatisfaction with present management practices. They have also been able to operational& PDS by constructing new facilities and/or changing management practices.

The aspect of the change process that has proven most difficult, however, is completing the refreezing phase. The biggest problem has been to maintain the momentum of change, often as the result of construction problems associated with opening a new facility. During the transition period, employees are most likely to need positive reinforcement and extra emotional and resource support, but they are least likely to receive them because other problems take precedence over their needs.

The transition period is a highly stressful time for employees. If administrators and supervisor fail to recognize this stress and focus only on construction issues rather than on their employees, they are likely to be disappointed in the outcome of their efforts to change.

Recommendations

It is critically important for administrators and supervisors to do an objective assessment of their organizational climate prior to the transition process. Such an assessment will enable them to gauge the degree of resistance among staff to the changes that are about to take place. When organizations implement change before the employees accept it, there is an increased likelihood that the attempt to change will fail.

A number of instruments are available for assessing organizational climate.' Although these assessments can be conducted in-house without hiring outside consultants, employees may be more willing to cooperate when the fear of reprisal from administrators and supervisors is removed. Correctional agencies in which high levels of stress are apparent among employees should do an annual assessment of their organizational climate as a management tool.

[1] The Federal Bureau of Prisons' Social Climate Survey (Saylor, 1983). Spector's (1985) Job Satisfaction Survey, Spielberger's (1983) State-Trait Anxiety Inventory. Stress Effects Inventory and Stress Behavior Inventory in Human Services (Farmer. Monahan, and Hekeler, 1984). and the Job Diagnostic Survey (Hackman and Oldham, 1975) are some of the measures that have been used in previous research and could be used either alone or together to obtain a comprehensive assessment of the organizational climate and related work issues.

In summary, it isimportant to monitor staff attitudes prior to implementing thechange process, during the transition, and after change has occurred. Too often. the most important resources of an organization-the employees-are neglected in the excitement of making a transition to a new facility and/or a new management philosophy.

During the transition period, employees are likely to need positive reinforcement and extra emotional and resource support, but other problems often take precedence over their needs.

For further information, contact Linda G. Smith, Ph.D., Department of Criminology, University of South Florida, Tampa, Florida, 33620; (813) 974-2815 or (813) 920-4189. ■

References

Brown, P. 1987. "Probation Officer Burnout: An Organizational Disease/An Organizational Cure, Part II." *Federal Probation* 51:17-21.

Cheek F., and M. Miller. 1983. 'The Experience of stress for correctional Officers: A Double-Bind Theory of *Correctional Stress." Journal of Criminal Justice* 11(2):105-20.

Cournoyer, B. 1988. "Personal and Professional Distress Among Social Caseworkers" *Social Casework* 69:259-64.

Duffee, D. 1986. *Correctional Management: Change and Control in Correctional Organizations.* 2d cd. Prospect Heights, Illinois: Waveland Press.

Fanner, R., L. Monahan, and R. Hekeler. 1984. *Stress Management for Human Services.* Beverley Hills: Sage Publications.

Hackman, J., and G. Oldham. 1975. "Development of the Job Diagnostic *Survey." Journal of Applied Psychology* 60:159-170.

Higgins, J.. and J. Vincze. 1986. Strategic *Management and Organizational Policy.* 3d ed. Chicago: The Dryden Press.

Hodgetts, R., and D. Kuratko. 1988. *Management.* 2d ed. San Diego: Harcourt Brace Jovanovich Publishers.

Lewin, K. 1958. "Group Decision and Social Change." In *Readings in Social Psychology.* Macoby, et al., eds. New York Halt, Rinehart and Winston.

Sauter, S., J. Hurrell, and C. Cooper. 1989. *Job Control and Worker Health.* Chicester, England: John Wiley and Sons.

Sayior. W. 1983. *Prison Social Climate Survey Scale.* Washington: U.S. Department of Justice. Federal Bureau of Prisons.

Spector, P. 1985. "Measurement of Human Service Staff Satisfaction: Development of the Job Satisfaction Survey." *American Journal of Community* Psychology 13:693-713.

Spielberger. C. 1983. State-Trait Anxiety Inventory: Form Y. Palo Alto: consulting Psychologists press.

Williamson, H. 1990. *The Corrections Profession.* Newbuy Park, California: Sage Publications.

Wismer, J. 1979. "Organizational Change: How to Understand It and Deal with IL" *Training/* 16(5):28-32.

Telephone Triage: An Innovation for Efficiency in Jail Health Care

by Cecil Patmon, Nurse Program Manager, Martinez Detention Facility, Contra Costa County Sheriff's Department, Martinez, California

The word "'triage," like the word "ombudsman," has come to have a variety of meanings depending on the setting in which it is used. Triage is, of course, not a new concept The word itself, which is French for sorting or choosing, was introduced into English during World War I to describe a system used by medical professionals to classify the wounded into three groups:

- those too severely wounded to survive;
- those would recover even without treatment; and
- those who would survive only with immediate help.

Obviously, it was the third group that received priority treatment.

This practice of providing care based on a determination of those with the most urgent need is used in emergency rooms nationwide. Kaiser Permanente, one of the country's oldest health maintenance organizations (HMOs), adopted the concept under the term "advice nurse."

Given the finite pool of medical resources, it is easy to understand the appeal of this practice. To make maximum use of limited resources it is necessary to protect them from frivolous or unwarranted use. At the same time, it is important to protect the health consumer from an arbitrary denial of access to services. The triage approach is a natural way to meet this combined and seemingly contradictory need.

Triage's decision-tree process has traditionally been applied to providing urgent or emergency services. Its application to routine cafe was a revolutionary step; it was even more revolutionary to introduce this concept into the correctional health care system.

Before the National Commission on Correctional Health Care articulated nationally accepted standards of care, the provision of health services in corrections was, in the main, disjointed. With tional health care providers began to spend substantial resources and effort to ensure a Constitutional level of care. This commitment was capped by the drive for national accreditation on the part of correctional systems around the country.

However, the economy took a precip itous downturn in the late '80s, placing an enormous burden on states and local governments to cut expenditures. Nowhere was this requirement to trim budgets felt more acutely than in corrections. It cut across program lines, often in the face of court-ordered mandates to preserve the integrity of programs and provide services.

As often happens, however, adversity stimulated creativity. This was the case in Contra Costa County, California, with an inmate population of approximately 1200, where deep cuts in mandated services were necessitated by reduced revenues. Among the methods proposed for cutting health manpower costs in the county's jails was "telephone triage."

Nurses' telephone screening of inmates' health complaints ensures access to proper care while cutting health care personnel costs.

Setting up the telephone triage system was quite straightforward. Dedicated phone lines were established between the housing units and the medical department. Medical services staff, with input from custody staff, then allocated times when each housing unit's phone would be activated.

During the designated times, a triage or "advice" nurse receives calls and triages them for the level of need, based on the timeliness of intervention required. Emergency problems are handled outside the triage system, through the unit officer.

Each regular call is assessed based on structured, written protocols. The nurse may give instructions for self-care or write nursing orders and make an appointment for the patient for clinic screening or sick call If physical information is needed, a clinic nurse obtains it and confers with the advice nurse for disposition, The triage policy spells out appointment schedules on a priority needs basis for non-emergency cases requiring cam by medical staff. Categories are:

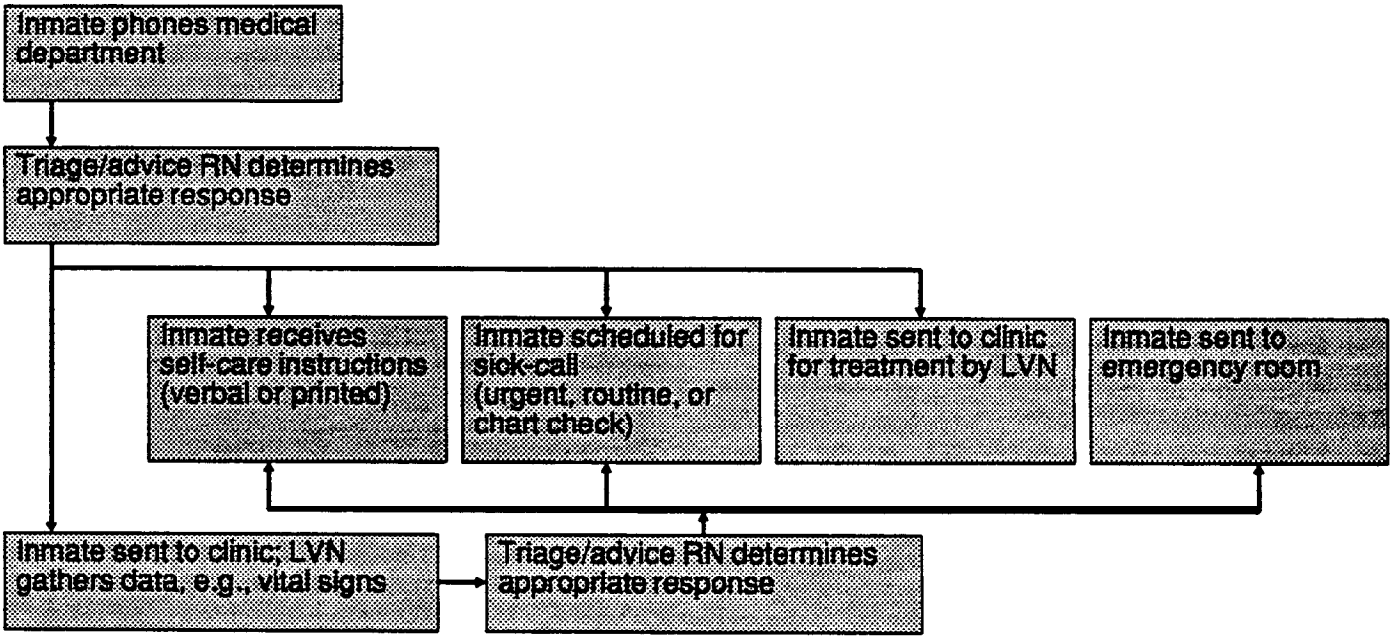
- Urgent-given the next available appointment;
- chart check-seen the next sick call day; and
- Routine-seen within two weeks.

Structured protocols and a standard triage form ensure that consistent informationis obtained no matter who is responding. Nursing staff can now effectively manage many complaints that were formerly handled at sick call, which required more costly resources. Seeing inmates who do need sick call visits requires less time than before because a better database exists. Documentation and patient follow-up have also improved.

The triage system has been very successful. Within the past three months, it has been instituted at another county facility and is slated for a third facility later in the year. The telephone triage system has proven effective in addressing the continuing problem of declining revenues and finite health care resources in the jail setting.

For further information, contact Cecil Patmon, Nurse Program Manager, Health Services, Contra Costa County Sheriff's Department, 1000 Ward Street, Martinez, California, 94553; (510) 646-1641. At the West County Detention Facility, contact Laverta Guy, Nurse Program Manager; (510) 262-4370. ■

The Triage Screening Process



Fairfax County's Town Meetings Give Minorities a Voice in the Criminal Justice System

by Sarah Cox,
Criminal Justice Policy Group, Fairfax, Virginia

How is the criminal justice system perceived by minorities? Do minorities believe that the system is fair? In Los Angeles, these questions were raised dramatically in the riots following the Rodney King decision. In Fairfax County, Virginia, the chief judge of the circuit court, the Honorable Richard J. Jamborsky, inspired county leaders to seek proactively for answers to such questions rather than wait to see if civil unrest would occur. Following Judge Jamborsky's suggestion, the Fairfax County Board of Supervisors asked one of its advisory bodies, the Criminal Justice Policy Group, to determine minorities' perceptions of the criminal justice system and its fairness.

The Criminal Justice Policy Group, chaired by Sheriff Carl Peed, consists of the heads of all criminal justice agencies in the county. The group immediately appointed representatives to develop a plan for what the board of supervisors had called a "symposium" on the criminal justice system.

County Population Shifts

Fairfax County, Virginia, once a suburban bedroom community in the metropolitan area surrounding Washington, D.C., is now a rapidly growing urban area with its own business and employment centers and a population approaching 1,000,000.

Between the 1980 and 1990 censuses and continuing today, the population of minorities in Fairfax County has been growing much more rapidly than the white population or the population as a whole. African-Americans now constitute some 8 percent of the population; Asians, 9 percent; and Hispanics, 7 percent. Asians tend to be under-represented in the criminal justice system, but African-Americans and Hispanics are over-represented: Hispanics make up about 14 percent of the inmate population of the Adult Detention Center and African-Americans about 30 percent.

Citizen Involvement

The planning committee, led by Sheriff Peed, soon realized that if the group wanted to hear what the minority populations of the county felt about the criminal justice system, the meeting could not be called a symposium. Officials from the criminal justice system needed to listen, not make speeches. Moreover, the meeting could not be held in the courthouse; the system needed to reach out into the communities and hear from people in their own neighborhoods. The committee also needed help from the minority groups themselves, to assist in publicizing the plans and in getting people to attend.

Thus, the committee started calling the effort "Town Meetings on the Fairness of the Criminal Justice System" and planned to hold five to ten such meetings around the county. It began to reach out to community groups of all kinds for help in planning and organizing the town meetings.

What had been thought of as a fairly simple symposium had turned into a complex operation. Before long, nearly 100 citizens, along with a large number of criminal justice staff members, were involved in planning for the town meetings. There were local task forces working on the arrangements for each town meeting, a large central committee overseeing planning, and subcommittees working on a format for the meetings and on public relations.

Many who participated in the planning process believe that the number and variety of persons involved **may** have brought about the most

powerful and longest-lasting effect of the town meetings. Participants came from all parts of the county and included representatives of a number of ethnic groups, social welfare groups, church groups, victims' groups, mental health, and women's groups, as well as general citizen organizations and county and state agencies. Many of the citizens who took part have said they want to go on meeting and to stay involved with helping the criminal justice system address its problems and communicate with its constituents.

The number and variety of persons involved in planning the town meetings may have brought about their most powerful and longest-lasting effect.

Meeting Format

Ultimately, six town meetings were held, each with the same format. Following a brief presentation about the criminal justice process, participants were divided into discussion groups with a trained leader; a trained recorder, and a set of discussion questions that each groups was asked to consider.

One meeting, held in an area with a high concentration of Hispanics, was conducted completely in Spanish Feeling that Hispanics can be reluctant to confront authority figures, the Hispanic organizers of this meeting were afraid no one would come. However, between forty and sixty people attended, and they wanted to go on discussing the issues when it was time to stop.

What Did We Learn?

As this article is being written, we are still analyzing the findings from the town meetings. One thing we are sure of is that most people do not understand the criminal justice system very well but, given the right opportunity, are eager to learn more about it. We also need to find better ways to educate our immigrant populations about American laws. We should not have to put people in jail to teach them that public drinking, drunk driving, abusing spouses or children, or leaving young children alone are not acceptable behaviors in this country.

Perhaps 200 citizens who had not been involved in the planning and were not part of the criminal justice system attended the meetings. We believe this number suggests that there is no large ground swell of unrest among Fairfax County's minority citizens. However, we did hear criticisms and will be working on ways to address the problems we learned about.

Changes in Fairfax County's criminal justice system will include:

- getting more and better interpreter services throughout the system;
- improving the jury system;
- hiring mom minority and bi-cultural employees in all agencies; and
- training all employees in multi-cultural awareness and sensitivity.

We have already seen some useful outcomes. During the course of the town meetings, new magistrates were hired, including an African-American and a multi-lingual Laotian, who had learned about the openings during the planning process.

Whatever the final outcome, the process has been as important as the product. The value of a small group discussion in a rearranged elementary school classroom, where a judge, a prosecutor, a sheriff, and a clerk of the court sit down in a circle with African-American, Hispanic, and Asian victims, defendants, recovering drug addicts, and ordinary citizens to talk about fairness in the criminal justice system and to listen to their neighbors cannot be matched by any textbook analyses or paper polls.

For further information, contact Sarah J. Cox, Criminal Justice Policy Group, 4110 Chain Bridge Road, Fairfax, Virginia, 22030; (703) 246-3247. ■

Public or Private Medical Services: Why Not the Best of Both Worlds?

by Ernest R. Williams, M.D., M.P.H., Medical Director, HCA/Correctional Medical Services, Orange County Jail, Santa Ana, California

It is now recognized that inmates have a Constitutional right to health care based on the Eighth Amendment prohibition against cruel and unusual punishment Federal courts began to recognize this right in the early 1970s in response to the increasing number of prisoners' petitions for relief from conditions of their confinement In *Ramsey v. Caccone,* the court concluded that, having custody of the prisoner's body and control of the prisoner's access to medical treatment, prison authorities have a duty to provide medical attention.[1]

"Cruel and unusual" cannot be defined with specificity, but, generally speaking, punishment that amounts to torture, or that is grossly imposed, or that is inherently unfair, or that is unnecessarily degrading, or that is shocking or disgusting to people of reasonable sensitivity is cruel and unusual punishment.[2]

An example is cited in the case of *Neuman v. Alabama,* where there was evidence of serious shortages of staff, equipment, and supplies. Unsupervised inmate assistants were allowed to administer treatments, dispense medication, and perform suturing and minor surgery. These assistants allowed acute cam patients to be left unattended for extended periods of time. A specific example of such neglect was a quadriplegic who endured a maggot-infested wound resulting from unchanged dressings. This was enough to shock the average person's sensitivity and therefore was considered cruel and unusual punishment[3]

Actionable circumstances result when the level of medical care available to a confined and dependent population is inadequate to meet predictable health cam needs because of obvious and sustained deficiencies in professional staff, facilities, and equipment.

Three basic health care rights have emerged from case law:

- the right to access;
- the right to care that is ordered, and
- the right to a professional medical judgment

These rights must be addressed by correctional health care providers. However, the question of whether it is better to provide these services through public, in-house medical services or through a contract with a private provider has not been definitively answered.

Personal Observations

When I began to work in corrections in 1978, I worked with a staff that was dedicated to providing the best possible health cam to incarcerated persons. My associates planned to finish their careers as health care professionals; it was to be their life--time work. They enjoyed working in a system that allowed them to provide quality medical services. Although they were conscious of costs, they were not burdened by the need to do more with less. They were instrumental in improving the medical status of individuals who either had no interest in their own health condition or became aware of unmet medical needs after being incarcerated. They interacted with correctional personnel and trained them to recognize urgent and emergency medical and mental health problems. Their services resulted in more rapid medical intervention, which decreased residents' morbidity and mortality and also benefit-ted the institution and community at large.

It is important to rememberthat as many residents are discharged from jails as are housed in them. Thus, medical problems that exist in jails simply mirror those that exist in the

community. Incarceration provides health cam professionals with the opportunity to make quality health assessments and complete treatment plans, when inmates can be held long enough to address some of their unmet needs.

Aspects of Privately-Provided Jail Health Care

Privatization is not a new concept. In 1973 Peter Drucker defined privatization as the use of private enterprise rather than government to satisfy the country's social and economic needs. Privatization, or contracted services, would produce an infusion of choice and competition, resulting in cost savings and greater efficiency.[4]

The premise of the private system is that the user can make a choice and the marketplace will determine its success or failure. Although, as I have indicated, merely being incarcerated affords a person the right to health care, anincarcerated consumer no longer has the right to choose a particular system of health cam. The factor that leads to competition in the marketplace-choice-is not available to the consumers but to the purchasers of these setvices: the wardens, sheriffs, and superintendents.

As these officials are not the consumers of services, they often find a lesser package more appealing because it costs less. Private health cam providers attempt to bundle health care into neat packages, each having its own price tag. A lesser package may meet the needs of the administration but not the needs of the consumer. price tag alone is not a guarantee of quality.

In principle, private contractors emphasize prevention, health education, behavior modification, and quality improvement I am supportive of all these principles, as they prevent the more costly health problems that come with neglect

However, jails are filled with people who ate there only a short time. The health care needs of this population are episodic. Providers of services therefore have little time for prevention and behavior modification. Because there is always an urgent or emergency situation, the system is mom akin to an urgent care facility than a long-term, sustained health care system.

Residents of jails are likely to require the use of hospital emergency moms and skilled health care professionals. As a result, the cost to provide medical services is higher than in the community. It is predictable that, sooner or later, the cost savings experienced in an initial contract year will decrease substantially, as reviews show shortfalls in services or as real needs become more apparent. The bottom line will then approach that of well-run public providers.

In addition, there is often an administrative layer between the provider and the payer. These administrators are responsible for seeing that the system works and that contracted services are received. They am often driven by the profit motive to cut costs where possible. Although they are usually not physicians. they make decisions customarily made by those with medical training. They use computers, computer analysts, accountants, lawyers, and corrections personnel to make health care decisions. They can be quite forceful and can coerce knowledgeable physicians to acquiesce to their wishes for fear of losing their jobs.

Potential Problems with Publicly Provided Care

The public system of jail health cam can also have problems, however. The incarcerated population often needs immediate hospital care. When these services are provided on-site, they are sometimes provided in a poorly equipped medical area that does not meet residents' emergency needs.

Private sector contract administrators rely on computers, analysts, accountants, lawyers, and corrections personnel when making health care decisions that are customarily made by those with medical training.

In addition, some facilities' utilization of new, less experienced correctional health care professionals can result in barriers to access for the troublesome patient and a tendency to allow subjective complaints to develop into acute health care problems.

Although the use of mid-level practitioners such as nurse practitioners (NPs) and physicians' assistants (PAs) is a cost-effective way to provide services, this approach requites close supervision by a physician, which is not always possible.

If you have a committed staff that has provided good medical services, but cost reductions are necessary, there may be ways to save money other than contracting for services.

This means that some people are seen only by mid-level practitioners who may interact with the physician supervisor only when complications have developed.

In addition, there is a tendency for mid-level practitioners to become "mini-does" and assign some of their tasks to registered nurses (RNs) and licensed vocational nurses (LVNs). When this happens, the treatment plan starts in the wrong direction, and residents do not receive the care they need.

The Importance of Efficency

These few paragraphs do not allow me to address all the concerns that should be taken into consideration when making a decision about whether to privatize health care in correctional settings. The needs in jails are different from those in prisons, and some for-profit systems can provide quality services because they are mindful of these differences.

I would advise, however, that before making a decision in favor of privatized health care, you take a good look at your present system. If you have a committed staff that has provided good medical services, but cost reductions are necessary, there may be ways to save money other than contracting for services.

For instance, if you are spending an excessive amount on hospital and emergency mom costs, it may be because your system does not do adequate intake screening, which means that sicker people are admitted into the jail. You may need to have medical rather than correctional personnel perform the intake screening.

It is also possible to meet with hospital administrators and negotiate a rate that fits your budget. You can do some of these things on your own, rather than having a private contractor do them after you have signed on the bottom line.

The present system of health care in jails is costly not because of the quality of the worker or the leadership but because of the bureaucracy. Existing providers need to look at ways to become more efficient. private providers are aware of the importance of addressing the areas of budget, automation, linkages with public health agencies, modernization of equipment, health education, and reduction in staff size. These issues are seldom discussed within public organizations.

Budgets could be allocated directly to health care administrators. This would place responsibility and control directly in the hands of individual departments, making them responsible for gains and losses and producing a more efficient operation. Under the current budgeting system, individuals in control of budgets may reject an innovative change because they are not involved in the program.

In this era of automation, it is also inefficient to try to provide jail health cam without a computer system. The need for linkages between public health agencies and correctional health providers is ineacapable. Jail populations are a reflection of the community; a jail health issue is a public health issue.

Considering Privatization

To help you make the decision of whether to contract for health services, I recommend that you confer with a consultant who specializes in institutional health care. If you decide to privatize, do not hesitate. Once contracted services are underway, however, make sure your review process looks at what is actually being provided as opposed to what is *said* to be provided.

When considering whether to provide correctional health care services by contracting with a private provider:

- Review your present system. Determine if there are ways that it can be changed to provide the mandated level of care by updating, x-e-educating, or making other adjustments.
- Obtain the services of an experienced consultant to review your present system and make recommendations for improving it or resolving problems.
- Consider all alternatives.
- Make an informed decision. The final cost should not be the only determinant in your decision. Instead, base the decision on a number of factors, including final cost, the level of services actually provided to residents, and a concern for potential litigation.

If you decide to use a private contractor to provide health care services, negotiate the contract on a two-yearrenewal basis. This will allow a regular opportunity for review and for change, if it is needed.

Privatization is an alternative way to provide services, but cost should not be the major factor in choosing that alternative. Providers of health care must compete on quality, service, and reliability first, then cost.[5]

Providers of health care must compete on quality, service, and reliability first, then cost

For further information, contact Ernest R. Williams. Medical Director, HCA/Correctional Medical Services, Orange County Jail, 550 N. Flower, Santa Ana, California, 92701; (714) 647-4169. ■

References

1. B. Jaye Anno, *Prison Health Care: Guidelines for the Management of an Adequate Delivery System (Washington,* D.C.: U.S. Department of Justice, National Institute of Corrections. 1991). p. 33.

2. *Ibid.*

3. *Ibid.*

4. *Randall Fitzgerald, When Government Goes Private* (New York Universe Books. 1988). p. 8.

5. Lawrence A. Hamilton, *Quality Improvement Methods: A Simplified Approach* (Westminster, California: Lawrence A. Hamilton Co.. 1991). p. 12.

Allegheny County Jail's "Out-Patient" Mental Health Program

by Charles Kozakiewicz, Warden, Allegheny County Jail, and Sharon L. Ciocca, LSWACSW, Director of Mental Health, Correctional Medical Systems, Pittsburgh, Pennsylvania

The mentally ill offender is no longer adrift in the Allegheny County criminal justice system because a number of psychiatric services have been developed to improve the quality of cafe provided to these offenders. One of these services is a licensed out-patient program within the confines of the Allegheny County Jail.

Since a federal court order mandated a mental health program in 1980, the program has met state licensure regulations and Allegheny County Mental Health-Mental Retardation requirements. Correctional Medical Systems, a private company under contract with Allegheny County to provide all medical and mental health care, has established standards governing the operation of the mental health program.

The primary aim of the program is to provide psychiatric services to inmates in need of such care. When an inmate first enters the institution, he or she is screened for any obvious medical or psychiatric problems. Suicide prevention screening is also provided for every entering inmate.

Acute Care Services

The Allegheny County Jail's Mental Health Unit is an acute care unit that can accommodate twenty inmates. The unit provides milieu therapy through its environment, as well as supportive-directive psychotherapy, crisis intervention, and chemotherapy. A psychiatrist completes a psychiatric evaluation of all inmates housed in the unit. In addition, a psychiatric aide does a psychosocial history, and a mental health nurse and the treatment team prepare a treatment plan. The treatment team consists of the psychiatrist, a mental health nurse, a psychiatric social

Mental Health Program Criteria

Admission Criteria

- Observation by the screening registered nurse
- Collateral information from the inmate, correctional officers, an outside agency, or the family
- Destructive behavior
- Gestures, behavior, or threats of behavior indicating potential harm to self or others
- Existence of acute or chronic disorders that cause an inability to function in the general population
- Existence of a complex drug withdrawal state
- Identification by the Allegheny County Behavior Clinic or the Diversion Program as a potential candidate for commitment

Length of Stay Criteria

- Continued need for observation
- Persistent destructive tendency
- Persistent inability to function
- Ongoing symptoms of drug withdrawal
- Pending transfer to psychiatric care facilities

Discharge Criteria

- Observations completed; no further need for observation and/or treatment
- Cessation of destructive behavior
- Sufficient remission of psychiatric symptomatology to permit functioning in general population
- Cessation of drug withdrawal symptoms

worker, and a psychiatric aide. The team uses a holistic approach to treatment in that it also completes a health history that identifies any medical problems.

A psychiatrist is available six days a week and is on call twenty-four hours a day, seven days a week. Psychiatric social workers work on a daily basis with designated mentally ill inmates.

Inmates in the mental health unit who have received psychiatric clearance have privileges such as personal visits and use of the gymnasium and law library.

Additional Mental Health Placements

Some inmates are discharged from the Mental Health Unit to the Intermediate Unit. This unit can accommodate an additional twenty inmates and is considered a "step-down unit" for those who have reached a stabilized level of mental health. The jail also has an Interim Unit, which houses up to twelve inmates whose symptoms are chronic and who are unable to function in the general population of the institution.

Psychiatric services are also available for female offenders, who are housed at the Allegheny County Jail Annex. Six cells are designated for female inmates who require suicide precautions or close observation.

In the event an inmate's condition warrants commitment to a psychiatric care facility, he/she may be committed by either the Allegheny County Behavior Clinic or the Allegheny County Forensic Diversion Program.

Continuity of Care

A Client Information System tracks inmates through the jail's mental health program. Inmates referred to the mental health program are given a client case number that serves as a tracking device. Information is obtained by a Client Information Specialist, who plays an integral role in the program.

Continuity of care is a major component of the Mental Health Program and is emphasized in the discharge planning process. In essence, discharge planning begins when the inmate is admitted to the Mental Health Unit. Whether an inmate is transferred to another correctional facility or released to the community, the unit provides continuity of care and follow-up. Psychiatric social workers make referrals to local community mental health centers or state institutions. Staff also contact ancillary agencies, if appropriate.

The program provides discharge planning in conjunction with local community mental health centers for inmates released to the community who need follow-up care. Each community mental health center in Allegheny County has a designated Intensive Case Manger, Criminal Justice Liaison, to ensure continuity of care.

Continuity of care is a major component of Allegheny County's mental health program.

Program Expansion

At present, at least 25 percent of Allegheny County Jail inmates are under the care of the mental health program. This is a result of the ever-increasing number of individuals remanded to the jail with a significant history of mental health problems.

The mental health program will expand in December 1994 with the opening of the criminal justice complex that will house the new Allegheny County Jail. The facility's mental health unit will provide more than 100 cells to accommodate the needs of both male and female mentally ill offenders.

For further information, contact Warden Charles Kozakiewicz or Sharon Ciocca, Director of Mental Health, Allegheny County Jail, 440 Ross Street, Pittsburgh, Pennsylvania; (412) 255-0100. ■

The John E. Goode Pre-Trial Detention Facility: A Proactive Approach to Design and Construction

by Michael A. Berg, Deputy Director, Jails and Prisons Division, Duval County Sheriff's Office, Jacksonville, Florida

On April 5-6, 1991, under direction of Sheriff James E. McMillan, the Office of the Sheriff, Jails and Prisons Division, Jacksonville, Florida, moved more than 1,700 inmates of various classifications from seven separate facilities around Duval County into the new John E. Goode Pm-Trial Detention Facility. This move was the culmination of more than sixteen years of intensive planning, research, and development efforts to solve long-standing problems related to incarceration in the county.

Like correctional systems in many other municipalities during the early 1970s. Jacksonville's was struggling with serious crowding and the consequence of the courts' increasing involvement in jail operations. The activism of the courts was brought home to Jacksonville in 1975, when the U.S. District Court for the Middle District of Florida issued a permanent injunction on behalf of inmates of the Duval County Jail.

As a result, jail administrators were put in the difficult position of having to correct long-standing deficiencies in the existing system as well as undertake the enormous task of finding new approaches to the traditional problems of crowding and recidivism. Having simultaneously to manage an ongoing crisis and find the resources to plan for the future was extremely difficult Our main facility, the Duval County Jail, built in 1956 with a design capacity of 448 inmates, was one of four facilities operated by the Jacksonville Sheriffs Office in 1975. At the time the federal court stepped in and mandated sweeping reforms, the jail had an population of more than 800 inmates.

Interim Responses to Crowding

One of our first efforts to respond to the federal court order was to institute innovative pretrial release programs, such as signature bonds, surety bonds, **cash bonds, release on own recognizance (ROR), notice to appear, and "jail sweeps"** (mass releases). Although these programs had aninitial impact, the inmate population continued to climb, partly as a result of the ongoing war on illegal drugs.

To deal quickly with the rising inmate population, we took possession of an abandoned juvenile shelter, pouring several million dollars in salaries and repairs into this outdated facility to bring it into compliance as an overflow housing facility. Even before renovations to this annex were completed. it became necessary to turn to another facility, the James I. Montgomery Correctional Center. a county prison farm, for additional pretrial bed space. Although this change alleviated some of the burden on the Duval County Jail, it required transporting pretrial inmates forty-four miles round trip daily for court appearances and releases.

Daily crisis management to keep the population under the court-ordered cap was routine. Overloaded with day-today attempts to manage crowding and bring the jail into compliance with the court order, the sheriff directed the administration of the Jails and Prisons Division to request assistance from the National Institute of Corrections to help us

NIC's PONI workshops taught us to take ownership of the process—from researching alternatives to selecting a site and planning operations to monitoring construction, transition, and occupation.

plan for a long-range solution to the problems plaguing our system.

NIC's Planning of New Institutions (PONI) Program

In February 1981, NIC conducted a workshop. Planning of New Institutions (PONI). Phase I. in Jacksonville. This workshop brought together more than forty elected and appointed officials, correctional administrators, and city planners to plan an organized approach to our incarceration problems. Seven officials from local city government and representatives from the sheriffs office attended the follow-up PONI, Phase II, in Boulder, Colorado. These two PONI workshops taught us to take ownership of the entire process-from researching alternatives to housing, through selecting a site, to actively monitoring the construction, transition, and occupation phases. It quickly became apparent that this kind of hands-on overnight and attention to detail required a special team.

The Jail Planning Team

A Jail Planning Team was organized and charged with developing a comprehensive schedule for planning a new jail and conducting a pre-architectural needs analysis. As outlined by NIC, this endeavor would requite a project director and a three- to five-member full time staff. Recognizing the magnitude of the problem while accepting the city's economic constraints, the county organized a cross-departmental Jail Planning Team. Under the initiative of the sheriff, existing staff were reassigned to create this team. The Jail Planning Team was initially comprised of a city planner from the City of Jacksonville's Planning Division, a police planner from the Jacksonville Sheriffs Office, and a correctional officer from the Duval County Jails and Prisons Division. In addition, the Jail Planning Team used the contractual services of Dr. Robin Ford, Director of the Eastern Region of the National Criminal Justice Collaborative.

During this period, corrections in Jacksonville came of age. We were committed to finding solutions to traditional correctional problems through long range planning and modem management techniques. We took a systems approach to finding permanent answers to existing problems. We started viewing our entire operation as a business that needed to function as efficiently and effectively as possible.

With seven facilities spread over 750 square miles, our first step was to assess our current operations and try to consolidate all like functions such as commissary, computer, and property systems; policy initiatives; and classification processes. Consolidation, whenever appropriate, was the first order of business. Next we acquired basic operating equipment, including typewriters, calculators, computers, and radio communications equipment. Changing the mindset of the staff so that they viewed themselves as managers and administrators was also key in solving immediate and future problems.

The Jail Design Team

A second team, the Jail Design Team, was created by adding seven experienced correctional practitioners to the planning team. To take advantage of the planning team's previous work, representatives of the planning team merged with the correctional practitioners slated to work on the operational design of the new facility. Following the well-known design philosophy, "form follows function," we knew that if we expected optimum functioning facilities, we must lead the architects. Members of the design team toured several jails around the country that were newly opened or under construction to gather insight on facility design, layout, structural impairments to visibility, square footage considerations. as well as architectural and jail administrative thinking. We used these trips as a way to validate our thoughts on some of our own design initiatives and to eliminate ideas that did not mesh with our management approach.

The Jail Design Team's years of operational expertise blended with the knowledge and experience of the project architect to create a facility that was functional for us, the end user. This approach to designing and building a jail was a learning experience for all concerned. The architect was able to grasp our inmate manage-

ment philosophy and convert our ideas into walls, sections, and floors.

Every area of the new facility was scrutinized to guarantee its workability and compatibility with other areas. For example, the inmate intake area was one section where we knew that new methods could help us achieve greater efficiency. The design team was able to design a staff-efficient in-line intake, transfer/release, and holding area by utilizing holding cells that were separated by glazing. Interior and exterior transfer cell doors also made for a smoother interaction between the facility correctional officers who placed inmates into the cells and transportation correctional officers who removed them for transport to other criminal justice facilities.

The Design Team played an integral part in ensuring the maximum utilization of floor space, equipment, and systems.

As the Jail Design Team planned each section of the new facility, it called on area-specific correctional experts to hone the process further. Supervisors of key areas were then charged with following through on the planning, construction, and fitting of their areas to completion. Visiting the construction site became a routine duty for all correctional managers. This process was so effective that we were able to plan, build, and bring on-line two additional, smaller institutions during the construction phase of the Pre-Trial Detention Facility.

The design team was able to include many practical requirements in the design For example, the original drawings included a mechanical room on each housing floor, test rooms for officers were located on the mezzanine area of the housing floor. The team recommended that these areas be reversed, thus allowing the officers access to rest room facilities without leaving their posts.

Another example was that a stairwell was originally planned to cut through the back end of the trusty dining room. The team recommended that the stairwell be reversed, thus bypassing the trusty dining room altogether and increasing floor space. From installing remote cutoffs in the control rooms for water to the isolation cells, to adding tape decks to the public address system for informational and instructional taped messages, the Design Team played an integral part in ensuring the maximum utilization of floor space, equipment, and systems.

The Transition Team

At this point, we still had an enormous amount of work left to do both logistically and administratively to make the transition to a new facility and close four older units. Taking advantage of the knowledge and experience gained by the previous two teams, we formed a Jail Transition Team approximately one year prior to occupancy. A correctional lieutenant was selected as Transition Team Coordinator. and five correctional sergeants and one correctional officer were chosen for the team to add line level supervisory knowledge to the project. This team was responsible for meticulously organizing all aspects of the transition from old to new.

The transition process had nine distinct aspects:

- organization;
- administration;
- new facility personnel;
- transition training;
- security and safety;
- inmate programs;
- support services;
- move logistics; and
- post-transition issues.

Organization. Specific goals and objectives were put in writing to furnish the framework for the entire transition process. In addition, all planning activities for functional areas had to be developed.

Administration. The administration phase involved developing a new facility management plan that described operational concepts and procedures. The bulk of the transition team's work centered on the development of a post order and poli-

cies and procedures manual. Each area, section, activity, and position for the new facility had to be thoroughly researched. Written procedures were then put into a logical sequence to spell out in detail specific responsibilities for all staff members.

Requisition of new facility equip ment not supplied by the contract required an area-by-area analysis to identify the equipment needs for each cell, room, dayroom, office, and control room.

We worked closely with the news media to ensure positive news coverage and to keep the general public informed of the process. We knew that building a new facility would be expensive, and we wanted to show the public that we could be good stewards of their trust and money. In order to nurture this idea, we held carefully planned tours for local, state, and federal officials, community leaders, and friends and families of the employees and provided "open house" tours for the general public. Pamphlets were created and distributed to over 5,000 guests who participated in the open house. This effort was so successful that we scheduled an additional weekend of open house activities to accommodate the public.

We knew that building a new facility would be expensive, and we wanted to show the public that we could be good stewards of their trust and money.

Personnel. System-wide staffing had to be studied to establish whether we had sufficient personnel to operate the new facility adequately. Consolidating correctional officer positions from seven separate facilities into three facilities required a massive realignment of personnel. The Transition Team conducted an inmate population projection study to ascertain the number of officers needed to staff the new facility.

Transition Training. We realized that it was critical to train all correctional personnel prior to occupancy. With the aid of the contractors and subcontractors, Transition Team members prepared lectures and seminars. Each operational system-from electronic doors to complex fire control computer systems-had to be included in the transition training plan. Training schedules were arranged carefully to provide training to staff without conflicting with the ongoing shift work at the old facilities. Video tapes of specific systems in the new facility were provided by the contractor to use in the transition training. Our training academy's instructional procedures had to be revised to include new areas and procedures specific to the new facility. Again, it was important to work closely with the correctional liaison at the training academy in developing these procedures.

Safety and Security. The transition team had three primary objectives in addressing safety and security: to ensure the safety of inmates and staff; to maintain order within the facility; and to prevent escapes. Issues considered in formulating safety plans were inmate escort outside of the facility; control of contraband; inmate counts; tool, key, dangerous materials, and weapons control; control of drugs and medication; use of security equipment; and emergency plans for escapes, riots, disturbance, and hostage situations. In addition, plans were formulated for the emergency evacuation of inmates; adequate marking of emergency exits; tests of power generators; and training of staff to respond to any emergency Situation. The physical layout of the new facility had to be studied to ensure that security procedures were in place for each door, sallyport., or gate leading to an unsecured location.

Programs. In the area of inmate programs, we counted on resources already at our disposal through our Community Corrections Division. Through close coordination with the local community college and contract services with a substance abuse organization, we were able to develop new educational and rehabilitative programs. Scheduled programs were changed to accommodate both pretrial and post-trial inmates. Consolidation of programs

with our other two divisions led to a standardized schedule of all programmatic activities. Work crews for trusties were also standardized.

Support Services. Support services had to be considered early in the transition phase, as moving from a 448-bed to a 2,189-bed facility dramatically increased our need for these critical services. The Transition Team not only had to identify what support services were needed, but also who would supply them and how. These services included medical, dental, and mental health services; the services of a nutritionist to plan daily menus and special diets; regulation of inmate correspondence and access to telephones; management of inmate visiting, both contact and non-contact; control of commissary accounting procedures; laundry; distribution of personal hygiene articles to inmates; sanitation inspections of all areas; and other sundry services. In addition, the entire computer system for tracking inmates had to be restructured to accommodate the differences in the physical plant of the new facility.

Move Logistics. Issues related to move logistics were many and varied. Not only did the Transition Team have to prepare to move into the new facility but also to close the old facilities. This two-fold move plan involved numerous meetings and many staffhours. All equipment, furnishings, and supplies at the old facilities were inventoried to determine what items would be required at the new.

We developed a plan for the move that involved over 200 correctional officers. From classification of inmates, to staging, transportation, and reception at the new facility, to elevator control, inmate files, housing assignments, inmate property, and commissary, every correctional officerknew his/her job and what to do. What took over six months to plan took less than two days to accomplish because it was all done through meticulous planning and attention to detail.

What took over six months to plan took less than two days to accomplish because it was all done through meticulous planning and attention to detail.

Post-Transition. Once the inmates were moved into the new facility, our job was half over. The other half was to close the old facilities. Once again, planning and attention to detail helped to ensure the smooth closure of four outdated facilities. Every item that was salvageable was removed from the old facilities, including stainless steel toilets, steel bunks, shelving, and even fencing.

The Management Team

Finally, we realized that for a period of time there would still be modifications and alterations to our organizational and operational concepts and procedures after opening the new facility. It was the Management Team's responsibility to follow up on organizational and administrative initiatives in addition to arranging hands-on orientation to the new facility. Methods were developed to get feedback from staff concerning how well the new written procedures and equipment worked. Procedure/equipment problems were addressed twice a week at meetings that included senior jail administrators, line supervisors, line officers, and contract personnel. Through this feedback, we were able to take corrective action instantly.

Throughout the entire process, our team concept enabled us to take a proactive approach to planning, designing, and constructing the fifth largest jail in the United States. Through meticulous attention to detail, coupled with a hands-on team concept, Jacksonville Corrections was able to manage its inmate population, train the correctional staff, and build for the future of corrections in Duval county.

For further information, contact Deputy Director Michael A. Berg, Office of the Sheriff, Jails and Prisons Division, R-Trial Detention Facility, 500 E. Adams Street, Jacksonville, Florida, 32202; (904) 630-2120. ■

Recommended Reading

Detention in Transition: Sonoma County's New Generation Jail. Jackson, Patrick G., 1992. Sponsored by National Institute of Corrections. Jails Division (Longmont, CO). 57 p.

This study examines the nature and extent of change in inmate and staff attitudes, perceptions and behavior in relation to occupying the new Main Adult Detention Facility (MADF) versus the older buildings. The results indicate that the MADF is a safer and more secure environment than the older structures. The overall positive results are consistent with prior studies of similar facilities.

Exemplary County Mental Health Programs: The Diversion of People with Mental Illness From Jails and In-Jail Mental Health Services. Adams, Regina Drake, National Association of Counties (Washington, DC), 1988. Sponsored by National Institute of Mental Health (Rockville, MD). 28 p.

Contents discuss: a comprehensive approach to the provision of emergency mental health services; sheriff's deputies trained as mental **health technicians; in-jail** mental health treatment programs; and suicide prevention through training of jail staff. The document describes the Pinellas County (Florida) misdemeanor mentally ill program and forensic in-jail mental health program.

Jail Classification System Development: A Review of the Literature (Rev. ed). LIS, Inc. (Boulder, CO), 1992. Sponsored by National Institute of Corrections (Washington, DC). 69 p.

This review of the literature summarizes the history of inmate classification, the specific classification peculiarities characteristic of jail settings, and issues in the implementation of objective jail classification systems. This edition includes new sections on objective classification system components, computer applications in objective classification, and the use of criminal history data in making classification decisions.

Single copies of these documents may be requested by contacting the NIC Information Center at (800) 877-1461 or sending your request to 1860 Industrial Circle, Suite A, Longmont, Colorado, 80501.

Jailhouse Blues: Hard Time for County Taxpayers: A Study of the Rising County Costs of Incarceration in California. California Counties Foundation (Sacramento, CA), 1991.63 p.

Terming county jail costs a "fiscal cancer within county budgets," this report examines factors behind these escalating costs, including those contributing to overcrowding, drug use, the increase in city law enforcement activity, parole violations, sentencing dispositions, population caps and other court orders, delays in court processes, and incarceration as both a public policy preference and a last resort.

Offender Reimbursement to Local Jails: Report of the Virginia State Crime Commission to the Governor and the General Assembly of Virginia. Virginia State Crime Commission (Richmond, VA), **1992.**

The Crime Commission concludes that further study on recovering costs of incarceration from jail inmates is necessary because these is a lack of clear indication that the program would be beneficial to the State of Virginia, and a lack of clearly defined lines of responsibility in deciding which inmates should be charged for cost of cam or medical attention. ■